MICHIGAN DEPARTMENT OF STATE
DRIVER ASSESSMENT AND APPEAL DIVISION
P.O. Box 30196 - LANSING MI 48918-1601

PHONE: (517) 335-7051 FAX: (517) 335-2189

VISION SPECIALIST'S STATEMENT OF EXAMINATION

INSTRUCTIONS FOR DRIVER/APPLICANT:
You must complete the Driver/Applicant Section of this form completely prior to forwarding this statement to your vision specialist. A full name both printed and signed along with your driver license number is required for processing. Once you have this information legibly completed, you must have the remainder of this statement completed by a vision specialist. This request is based on results of vision screening at a local branch office, or other information received by this Department which indicates you may have a visual condition which may affect your ability to safely operate a motor vehicle. Information provided by your vision specialist must report vision condition from an eye examination performed within the past six months. The completed statement may be mailed to the address printed above.

RELEASE OF INFORMATION

I, (Please print or type) _____ hereby authorize and request that information regarding my visual condition be released to the Michigan Department of State.

DRIVER'S LICENSE NUMBER

DATE OF BIRTH

APPLICANT'S SIGNATURE

DATED

STREET ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE

AREA CODE

PLEASE NOTE: The Department may withhold licensing until this form is received and evaluated. Unsigned or incomplete forms will be returned and could delay processing of your application.

INSTRUCTIONS FOR VISION SPECIALIST

The Department of State asks your assistance in determining the visual condition of your patient. Your professional opinion, the answers to these questions and any other pertinent information will help the Department assess this individual's ability to safely operate a motor vehicle. Confidential information may be mailed directly to the Department at the address shown above. Please type or print your answers.

Certification by vision specialist's signature required on page 3.

FOR DRIVER ASSESSMENT USE ONLY

☐ Favorable ☐ set up _____ ☐ Refer for reexamination
☐ Restriction _____ ☐ Refer to Health Consultant
☐ Must Pass _____ ☐ Need additional information
☐ Unfavorable ☐ Medical ☐ Vision

REVIEWED BY

DATED

1. How long has this patient been under your care? _____ Years _____ Months

2. Date of most recent visual exam: | | | | | | | | | |

3. Visual acuity: (See page 4 for visual acuity standards. See Page 3 for "bioptic telescopic device" review.)

		Without Lens	With Present Lens	With New Lens
Right Eye	(OD)	20/	20/	20/
Left Eye	(OS)	20/	20/	20/
Both Eyes	(OU)	20/	20/	20/

3a. Were new lens prescribed? ☐ Yes ☐ No If yes, date of delivery: | | | | | | | | | |

3b. Does the driver have any progressive diseases of the eye? (See page 4 vision screening standards).

	Yes	No
Cataracts	☐	☐
Diabetic Retinopathy	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinitis Pigmentosa	☐	☐
Other	☐	☐

If other, please describe _____

3c. Specify other reasons for visual impairment _____

Doctor, please complete all peripheral fields.

4. Peripheral Vision -- Horizontal fields in degrees (See page 4 peripheral vision standards).

Less than 90° _____

Between 90° and 110° _____

Greater than 110° _____

4a. Do you suspect a visual field defect? ☐ Yes ☐ No If yes, how does it affect their ability to drive safely? _____

4b. Method used and test object size: _____

Tangent screen: _____ Perimeter: _____

Additional Comments and Request for Department Review

1. Should the Department require a periodic vision evaluation to monitor changes which may affect driving?
   ☐ Yes ☐ No If yes, how often? _____
2. Do you recommend that the Department request a Physician's Statement of Examination?
   ☐ Yes ☐ No
3. If you wish to make additional comments, please use the space provided below or additional sheets if necessary. _____

Bioptic Telescopic Device

Please complete this section if a patient requires the use of a bioptic telescopic device to operate a motor vehicle. Please fax or mail the completed statement to the Driver Assessment Support Section for final review.

Bioptic telescopic device training is necessary for the safe operation of a motor vehicle.

1. How long has the patient used a bioptic telescopic device when driving? _____ General use? _____
2. What is the power of the patient's bioptic telescopic device? _____
   2a. What is the patient's simulated acuity with a bioptic telescopic device? 20/ _____
   2b. What is the visual acuity when using only their carrier lens? 20/ _____
3. What training has the patient received to use a bioptic telescopic device to drive (e.g. classroom training, hours of training, on the road training, etc.)? _____
   3a. Was the patient's ability to drive evaluated using the bioptic telescopic device? ☐ Yes ☐ No (Please attach a copy of this evaluation with this statement).
   3b. Can this driver safely operate a motor vehicle at night using a bioptic telescopic device? ☐ Yes ☐ No
   3c. What training did this driver receive to use a bioptic telescopic device at night? _____
4. Should the Department consider any additional license restrictions based upon the patient's vision condition? _____
5. Please describe how this driver's visual condition may affect the patient's ability to drive safely: _____

VISION SPECIALIST CERTIFICATION

I certify that the statements contained in this form are true to the best of my knowledge.

DOCTOR'S SIGNATURE	DATED
NAME (Print or Typed) Optometrist or Ophthalmologist	
ADDRESS	
PROFESSIONAL LICENSE NUMBER	TELEPHONE NUMBER ( )

THE FOLLOWING STANDARDS DO NOT TAKE INTO CONSIDERATION OTHER CONDITIONS WHICH MAY REQUIRE FURTHER RESTRICTIONS OR DENIAL OF LICENSE.

If applicant has more than one condition present, read down the chart until all conditions are covered, e.g., a driver with progressive disease such as cataracts, **and** 20/100 or less in one eye will be evaluated under #3 below, not eligible for a license.

SUMMARY OF VISION SCREENING STANDARDS FOR DRIVER LICENSING IN MICHIGAN

Generally, drivers who meet screening requirements of 20/40 or better are granted full driving privileges unless a vision specialist recommends otherwise, or, other physical conditions require restrictions or denial of a license. Drivers who are screened at less than 20/40 fall into categories 1 through 4 below.

1. VISION **WITH NO PROGRESSIVE** ABNORMALITIES OR DISEASES OF THE EYE:
    - 1a. Less than 20/40 to and including 20/50 - **full driving privileges**
    - 1b. Less than 20/50 to and including 20/70 - **daylight driving only**
    - 1c. Less than 20/70 - **not eligible for licensing**

2. VISION **WITH PROGRESSIVE** ABNORMALITIES OR DISEASES OF THE EYE:
    - 2a. less than 20/40 to and including 20/50 - **full driving privileges**
    - 2b. less than 20/50 to and including 20/60 - **daylight driving only**
    - 2c. less than 20/60 - **not eligible for licensing**

3. DRIVERS WITH VISION OF **20/100 OR LESS IN ONE EYE** AND THE OTHER EYE AS FOLLOWS:
    - 3a. Up to and including 20/50 - **full driving privileges**
    - 3b. Less than 20/50 - **not eligible for licensing**

4. PERIPHERAL VISION:
    - 4a. 140° to and including 110° - **full driving privileges**
    - 4b. Less than 110° to and including 90° - **subject to additional conditions and requirements**
    - 4c. Less than 90° - **not eligible for licensing**

Authority granted under ACT. No 300 of the Public Acts of 1949, as amended.